ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

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February 21, 2008

The Honorable Henry A. Waxman, Chairman
Committee on Oversight and Government Reform
United State House of Representatives
2157 Rayburn House Office Building
Washington, District of Columbia 20515-6143

Dear Chairman Waxman:

I write in response to your request for Illinois-specific information regarding the effect of several recent proposals from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The following conveys our best estimate of the cost of each proposal over five years and its effect on Illinois Medicaid beneficiaries. The cost estimates are based the most recent data available. The CMS Medicare Economic Index has been used to project future costs.

- Cost limits for public providers (CMS 2258-FC). Based on preliminary estimates, Illinois will likely loose $255 million in federal financial participation (FFP) during the first year, based on current reimbursement rates and projected utilization. We estimate the reduction in FFP to Illinois over the next five years to be over $1.3 billion. The vast majority of this reduction will be due to reduced payments to public hospitals.

  As the providers of last resort, public hospitals play a vital role in serving not only Medicaid beneficiaries, but also the uninsured. Because Illinois has, relative to the size of the State, a low ($202.5 million) federal allocation for disproportionate share hospital adjustment (DSH) payments, we have used Medicaid payments in excess of Medicaid costs to maintain access to needed care by uninsured individuals who are not Medicaid-eligible.

  The federal DSH program, as it operates today, contains serious and fundamental flaws. The federal DSH allocations, largely an artifact of DSH spending levels in 1991 that, in some instances, were tied to provider donation programs that were viewed as abusive by Congress, bear little relationship to the reality of health care needs today. As artifacts of those—now sixteen-year old—spending patterns, the needs of the uninsured and the health care "safety net" are nowhere considered.

  The flaws in the DSH program can be seen in the following (federal fiscal year 2006) statistics:

  —Illinois administers the 5th largest State Medicaid program in the nation, in terms of covered individuals, and is 7th in total Medicaid spending, yet Illinois' DSH allocation is only the 15th highest.

  —In 1991, Congress established a target of 12% of total Medicaid expenditures for DSH. Due to the limitations on DSH payments and reductions in its federal allocation, Illinois' FFY 2006 expenditures under its DSH allocation represented only 2.07% of Medicaid expenditures. This compares unfavorably to the national average of 5.64% even more unfavorably when compared to the other large industrial states that are between 6% and 9%.

—Overall federal DSH funding provided for an average of $178 in DSH allotment per enrollee nationwide. But, Illinois' allocation of the federal total provided for only $85 per enrollee.

In order to address these flaws at the federal level, to cover the needs of the "safety net" and public providers, Illinois has been forced to use an upper payment limit strategy to fund care to uninsured individuals—the same population for which DSH payments were intended—provided by major Medicaid providers. The pending change in federal regulation, adopted by CMS in May (currently under an enforcement moratorium until May 25, 2008), will limit Medicaid reimbursement to government-operated facilities. Enforcement of the rule will create a serious funding problem for relatively low DSH states, like Illinois, that have relied on basic Medicaid reimbursement to make up the shortcomings in their DSH allotment.

- Elimination of graduate medical education (CMS 2279-P). Illinois eliminated reimbursement related to graduate medical education (GME) for most hospitals over ten years ago. However, certain specialty and government-operated hospitals are reimbursed under per diem rate methodologies that include historic costs associated with GME. We estimate that eliminating the portion of the rates that is attributable to the direct costs of GME will reduce FFP by $14 million during the first year and approximately $74 million over the next five years.

  Elimination of the direct costs associated with GME will also have a significant and adverse effect on the upper payment limits (UPL) for inpatient and outpatient hospital services. Again, because of the fact that Illinois has a relatively low federal DSH allocation, Illinois has used Medicaid payments in excess of Medicaid costs to ensure that hospitals (both public and private) are able to offset, in part, the cost of care for the uninsured and, thereby, to remain open and accessible Medicaid beneficiaries. Reducing the UPL constrains our ability to do this.

- Restricting the definition of outpatient hospital services (CMS 2213-P). Restricting the definition of hospital outpatient services affect Illinois' Medicaid program in several ways. It will reduce the UPLs for outpatient hospital services and, thereby, constrain the ability of states like Illinois to use the room in the UPL to supplement their relatively low federal DSH allotments. We estimate the total reduction across the three classes of hospitals to be on the order of $700 million. This change will simultaneously reduce the hospital-specific limitation on DSH payments (*i.e.*, Medicaid shortfall plus the cost of the uninsured), again, constraining reimbursement at the individual hospital level.

- Limiting provider taxes (CMS 2275-P). The reduction in the maximum allowable health care related tax has forced Illinois to reduce its provider assessment on institutions for the mentally retarded 6.0% to 5.5%, resulting in an immediate loss of $1.75 million each in tax revenue and FFP. This will result in an estimated five year loss of $9.3 million in FFP and an equal amount in tax revenue.

- Redefined rehabilitation option services (CMS 2261-P). Illinois currently spends about $286 million annually on rehabilitation option services. It is unclear from the CMS proposed rule what the impact will mean to Illinois. In reviewing specific provisions of the rule, it does not appear that the proposal would have much effect Illinois' current services. However, the proposed rule includes sweeping statements that prohibit claiming of services that overlap with other programs—statements which appear inconsistent with specific provisions of the rule itself. This lack of clarity prevents us from interpreting what the effect of the rule.

- School-based administrative and transportation services (CMS 2287-P). Illinois schools will lose about $82 million in FFP during the first year and about $429 million over the next five years.

  A significant component of the administrative claim for schools is reimbursement for the outreach functions that they perform on behalf of the Medicaid program. An immediate affect will be to

substantially impair the State's ability to identify and enroll low-income school children with medical needs—the very children who might benefit most from the department's medical programs. The elimination of this funding will also reduce the Illinois' ability to target mandated EPSDT services on those who would benefit most.

- Targeted case management (CMS 2237-IFC). Illinois currently spends about $76 million on targeted case management services. The feature of the proposal that would prohibit monthly reimbursement rates adversely affects our Early Intervention (IDEA part C) program which has developed a rather effective (targeted) case management component. Our best estimate is a loss in FFP of $5 million during the first year and $26 million over five years.

  The proposal also affects significantly case management services that are provided outside of the "targeted case management" State plan option. These include administrative case management services (provided in Illinois to various populations, including pregnant women, infants and toddlers, and children with specialized needs) and case management service provided to participants in various home- and community-based waiver programs.

  There are also additional costs incurred by other Illinois agencies that are not easily quantifiable within the reporting time limits of your request. Particularly troubling in the proposed rule is a prohibition of overhead costs associated with non-Medicaid agencies. To not allow overhead costs for the non-Medicaid agencies, when the direct costs are allocated pursuant to *OMB Circular A-87*, would contradict the provisions of the executive directive itself; which requires that costs be allocated to all benefiting programs. Agencies that have multiple purposes, by definition have overhead costs that are in support of multiple programs. The CMS proposal makes no sense and is contrary to general allocation principles utilized throughout the federal government. The proposed rule is also inconsistent with the recent CMS proposal regarding limiting government provider reimbursement to actual cost incurred.

This is a very quick and short description of our concerns regarding these CMS proposals. I appreciate your efforts in working with all of the states to help us resolve these important issues that will not only have a devastating financial impact on the State's ability to deliver Medicaid services, but unnecessarily limit medical access to beneficiaries. Please let me know if there is anything else we can to do assist.

Sincerely,

Theresa Eagleson

Theresa A. Eagleson, Administrator
Division of Medical Programs

Schneider, Andy

From: Theresa Eagleson [Theresa.Eagleson@illinois.gov]
Sent: Monday, February 25, 2008 5:57 PM
To: Schneider, Andy
Cc: jane.mellow@illinois.gov
Subject: RE: Response to Regulations

Andy,
I'm sorry this email got lost in a bunch of them Friday afternoon. The $700 million is the 5-year number for the outpatient change. The first year number is about $130 million. Thank you for your patience.
Theresa

Theresa Eagleson
Administrator, Division of Medical Programs Illinois Department of Healthcare and Family Services 217.782.2570 theresa.eagleson@illinois.gov

>>> "Schneider, Andy" <Andy.Schneider@mail.house.gov> 2/22/2008 2:48 PM
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Theresa: One question of clarification.

You indicate that the loss of federal funds from the outpatient hospital services regulation will be $700 million. Is that a one-year or 5-year number? (I need both one- and five-year numbers, if possible).

I'm hoping to finish the report this weekend, so if you could an answer this afternoon it would be much appreciated.

Andy

From: Theresa Eagleson [mailto:Theresa.Eagleson@illinois.gov]
Sent: Friday, February 22, 2008 2:17 PM
To: Schneider, Andy
Cc: jane.mellow@illinois.gov
Subject: Response to Regulations

<< File: 02-20-08 Cost of CMS rules waxman letter.pdf >>